

CHAPTER 3  
SECTION 3.2

## MUSCULOSKELETAL SYSTEM

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

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I. PROCEDURE CODE RANGE

20000 - 29909, 63075 - 63076

II. DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

III. POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered, subject to the provisions of 32 CFR 199 and the provisions of the "Policy Considerations" section below.

IV. POLICY CONSIDERATIONS

A. Endoscopic Release of the Transverse Carpal Ligement.

1. Effective October 1, 1993, endoscopic release of the transverse carpal ligament (29848) is a TRICARE benefit. Reimbursement for the procedure is limited to the total CHAMPUS Maximum Allowable Charge.

2. Endoscopic release is limited to one procedure per wrist. Repeat endoscopic release is not covered.

3. Endoscopic release is covered only for treatment of patients whose documented signs and symptoms of carpal tunnel syndrome (CTS) have not responded to a minimum of six weeks conservative therapy to include:

- a. Splints; and/or
- b. Nonsteroidal anti-inflammatory drugs; and/or
- c. Change of activities that produce CTS symptoms.

4. **Contraindications.** Endoscopic release of the transverse carpal ligament is excluded as a benefit when the otherwise qualified patient has any of the following:

- a. Previous carpal tunnel surgery;
- b. Previous surgery or concurrent medical conditions that preclude full extension of the involved wrist;
- c. Rheumatoid tendonitis of the involved wrist;
- d. Space-occupying lesion(s) in the involved carpal tunnel.

5. Endoscopic performance of any of the following procedures in the wrist is excluded:

- a. Tenosynovectomy;
- b. Neurolysis;
- c. Z-plasty;
- d. Carpal ligament repair;
- e. Release of Guyon's canal.

**B. Effective August 25, 1997, autologous chondrocyte implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the Food and Drug Administration.**

C. Muscle transfer performed to correct abnormalities of the eye, face, hands or feet resulting from Moebius Syndrome.

**D. Single or multilevel anterior cervical microdiscectomy with allogenic or autogenic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.**

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